UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 2 OF 14

Section 2: What You Must Pay

You have PPO coverage under this certificate. PPO coverage uses a "Preferred Provider Organization" provider network. What you must pay depends on the type of provider you choose. If you choose an "in-network" provider, you most often pay less money than if you choose an "out-of-network" provider.

The types of providers you may get services from are in the chart below.

Choosing Your Provider		
If you receive services from an In-Network Provider	If you receive services from an Out-of-Network Provider	
	Participating Provider* This out-of-network provider participates with BCBSM.	**Nonparticipating Provider*** This out-of-network provider chooses not to participate with BCBSM.
Provider accepts the BCBSM approved amount as payment in full. You will pay the least out-of-pocket costs: • Lower deductible • Lower copayment and coinsurance amounts • No copayment or coinsurance for certain preventive care benefits No claim forms to file	Provider accepts the BCBSM approved amount as payment in full. You will pay more out-of-pocket costs than what you pay if you see an in-network provider (unless you are referred by a PPO in-network provider): • Higher deductible, unless noted • Increased out-of-network copayment and coinsurance amounts • No deductible, copayment or coinsurance for certain preventive care benefits No claim forms to file	Provider does not accept the BCBSM approved amount as payment in full** You will pay the highest out-of-pocket costs (unless you are referred by a PPO in-network provider): • Higher deductible • You pay all charges that exceed the amount we pay for a service. • Increased copayment and coinsurance amounts, unless noted (e.g., see emergency services on Page 97). You must file claim forms
***Important:** Outside of the PPO network, a provider can either be participating or nonparticipating. Participating providers have agreed to accept our approved amount plus your out-of-network deductible, copayment and coinsurance as payment-in-full for covered services. Nonparticipating providers have not signed an agreement and can bill you for any differences between their charges and our approved amount. ** Some nonparticipating providers participate on a per claim basis.		

For more information about providers, see Section 4, "How Providers Are Paid." This will include our payment practices for physicians and other professional providers, *and* hospitals, facilities and alternative to hospital care providers.

What you must pay for covered services is described in the following pages.

The basic deductibles, copayments and coinsurances you must pay each calendar year are illustrated in the chart below and explained in more detail in the pages that follow. These are standard amounts associated with this certificate. The amounts for which you are responsible may differ depending on what riders your particular plan has.

	In-network	Out-of-network
Deductibles	$100 for one member $200 for the family (when two or more members are covered under your contract)	$250 for one member $500 for the family (when two or more members are covered under your contract)
Copayment	$10 per office visit, urgent care visit or office consultation $50 per emergency room visit	$50 per emergency room visit
Coinsurance (Percent copays)	50% of approved amount for private duty nursing 10% of approved amount for most other covered services	50% of approved amount for private duty nursing 30% of approved amount for most other covered services
Annual Out-of-pocket maximums	$600 for one member $1,200 for the family (when two or more members are covered under your contract)	$1,250 for one member $2,500 for the family (when two or more members are covered under your contract)
Lifetime dollar maximum	None	

For additional benefit-specific cost-sharing requirements, please see Page 14.

Deductible Requirements

In-Network Providers

You are required to pay the following deductible each calendar year for covered services provided by in-network providers:

- $100 for one member
- $200 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family deductible
  - If the one member deductible has been met, but not the family deductible, we will pay for covered services only for that member who has met the deductible.
  - Covered services for the remaining family members will be paid when the full family deductible has been met.

Deductible Requirements (continued)

Amounts applied toward an annual deductible for out-of-network services also count toward the deductible for in-network services. However, deductible amounts for in-network services are not applied toward the deductible for out-of-network services.

You are not required to pay a deductible for the following:

- Covered services performed in an in-network physician's office, including presurgical consultations
- Services in an in-network physician's office, except mental health and substance abuse services that are not equal to an office visit. These services will require payment of your deductible.
- Services subject to a copayment requirement
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Chiropractic spinal manipulation
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services (specific services are listed in Section 3 of your certificate)
- Provider-delivered care management services performed by designated in-network providers, as identified by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out-of-state.

If you have a rider that adds a deductible for in-network services, it will be waived for covered provider-delivered care management services.

We will not apply charges toward your in-network deductible if one of the following applies:

- The charges exceed our approved amount.
- The charges are for noncovered services.

Deductible Requirements (continued)

Out-of-network Providers

For out-of-network providers, you must pay the following amounts for covered services:

- $250 for one member
- $500 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family deductible.
  - If the one member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible.
  - Covered services for the remaining family members will be paid when the full family deductible has been met.

You will not be required to pay an out-of-network deductible for covered out-of-network services when:

- An in-network provider refers you to an out-of-network provider

You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network deductible requirements.

- You receive services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO network
- You receive services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, out-of-network deductible requirements may not be imposed for:

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography in instances where an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

While the out-of-network deductible requirements may not be imposed, covered services will be subject to applicable in-network deductible requirements (if any).

You may contact BCBSM for information regarding these professional services.

We will not apply charges toward your in-network or out-of-network deductible if one of the following applies:

- The charges exceed our approved amount.
- The charges are for noncovered services.

Copayment and Coinsurance Requirements

In-network Providers

You are required to pay the following copayment or coinsurance (percentage) amounts for covered services provided by in-network providers:

- $50 copayment per visit for facility services in a hospital emergency room. The $50 copayment is not applied if:
  - The patient is admitted or
  - Services were required to treat an accidental injury

  

  Copayments are **not** applied to emergency services received from physicians, whether in-network or out-of-network, for treatment for a medical emergency or accidental injury.

- $10 copayment per office visit (see Page 56 for details) **except** for:
  - First aid and medical emergency treatment
  - Prenatal and postnatal care visits
  - Allergy testing and therapy
  - Therapeutic injections
  - Presurgical consultations

- 50 percent of the approved amount for private duty nursing care

- 10 percent of the approved amount for most other covered services

  This 10 percent coinsurance does not apply to:

  - Services in an in-network physician's office, except mental health and substance abuse services that are not equal to an office visit. These services will require payment of your coinsurance.
  - Services subject to a copayment requirement
  - Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
  - Chiropractic and osteopathic spinal manipulation
  - Prenatal and postnatal care visits
  - Allergy testing and therapy
  - Therapeutic injections
  - Hospice care benefits
  - Preventive care services (specific services are listed in Section 3 of your certificate)
  - Presurgical consultations

In-network copayments and coinsurance amounts will not be imposed for provider-delivered care management services performed by designated in-network providers, as identified by BCBSM for services rendered in Michigan or the local Blue Cross/Blue Shield plan for services rendered out-of-state.

Copayment and Coinsurance Requirements (continued)

Out-of-network Providers

For out-of-network providers, you must pay the following amounts for covered services:

- $50 copayment per visit for facility services in a hospital emergency room. For your requirements on services in a Michigan nonparticipating hospital, see Page 115115. The $50 copayment is not applied if:
  - The patient is admitted or
  - Services were required to treat a medical emergency or accidental injury

  

  You do not have to pay a copayment for physician services, in- or out-of-network, for treatment for a medical emergency or accidental injury.

- 50 percent of the approved amount for private duty nursing care
- 30 percent of the approved amount for most other services

  You will not be required to pay the 30 percent coinsurance for covered out-of-network services when:

  - An in-network provider refers you to an out-of-network provider

  

  You must obtain the referral **before** receiving the referred service or the service will be subject to the out-of-network coinsurance requirements.

  - You receive facility and professional services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
  - A female member of your contract obtains a prescription contraceptive device from an out-of-network provider
    You receive services from a provider for which there is no PPO network
  - You receive services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, out-of-network copayment requirements may not be imposed for:

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography in instances where an in-network provider performs the test, but an out-of-network provider does the analysis and interprets the results.

While the out-of-network copayment requirements may not be imposed, covered services will be subject to applicable in-network copayment requirements (if any).

Copayment and Coinsurance Requirements (continued)

You may contact BCBSM for information regarding these professional services.

We will not apply charges toward your copayments that:

- Exceed our approved amount or
- Are for noncovered services

Benefit-Specific Cost-Sharing Requirements

Certain benefits have specific cost-sharing requirements as follows:

Chiropractic and Osteopathic Manipulation Therapy

You must pay a $10 copayment for each chiropractic spinal manipulation visit or osteopathic manipulative treatment in an **in-network** physician's office. Out-of-network services are subject to out-of-network cost-sharing.

When an office visit and manipulative treatment service is billed on the same day, by the same in-network physician, only one copayment will be required for the office visit.

Contraceptive Devices

Services performed by an in-network provider are not subject to any deductible, copayment or coinsurance requirements. Services performed by an out-of-network provider are subject to the out-of-network deductible requirements of your certificate, however, your out-of-network copayment and coinsurance are waived.

Contraceptive Injections

Services performed by an in-network provider are not subject to any deductible, copayment or coinsurance requirements. Services performed by an out-of-network provider are subject to the out-of-network deductible, coinsurance or copayment requirements of your certificate.

Hospice Services

Hospice services received from physicians and other approved professional providers or approved facilities are **not** subject to any deductible, coinsurance or copayment requirements.

Benefit-Specific Cost-Sharing Requirements (continued)

Mental Health Services and Substance Abuse Treatment

Mental health services and substance abuse treatment are subject to the same annual deductible, coinsurance and copayment requirements and maximums that apply to all other in-network and out-of-network services.

Some mental health and substance abuse services are considered by BCBSM to be comparable to an office visit. When a mental health and substance abuse service is considered by BCBSM to be comparable to an office visit, you pay only for an office visit as described in your certificate or related riders.

This means when these services are performed by an in-network provider, you have no in-network deductible. You will be responsible for the flat-dollar member copayment that applies to office visits. When these services are performed by an out-of-network provider, you will be responsible for your annual out-of-network deductible and the coinsurance amount that applies to covered out-of-network services.

Outpatient Diabetes Management Program (ODMP)

Diabetes self-management training under the ODMP benefit, when performed by an **in-network** provider, is **not** subject to any deductible, copayment or coinsurance requirements.

When performed by an **out-of-network** provider, diabetes self-management training **is** subject to the out-of-network cost-sharing requirements of this certificate.

All other services and supplies of the ODMP benefit **are** subject to the cost-sharing requirements of this certificate as described on Page 10.

Prescription Drugs

See the "Prescription Drugs" section beginning on Page 69 for conditions affecting what you pay for prescribed drugs.

Prescribed drugs obtained from a pharmacy are not covered in this certificate but may be covered in a prescription drug program certificate that accompanies this certificate.

Any deductible, coinsurance, or copayment requirements for prescription drugs are specified in a rider or riders that accompany this certificate.

Presurgical Consultations

Presurgical consultations received from in-network providers are **not** subject to any deductible, coinsurance or copayment requirements.

Benefit-Specific Cost-Sharing Requirements (continued)

Specified Organ Transplants

During the benefit period, the deductible, coinsurance and copayment requirements do not apply to the specified human organ transplants and related procedures.

Voluntary Sterilization for Females

Hospital and physician benefits for voluntary sterilizations for females are payable at 100 percent of the BCBSM approved amount as follows:

- Services performed by an in-network provider are not subject to any deductible, copayment or coinsurance requirements.
- Services performed by an out-of-network provider are subject to the out-of-network deductible, copayment and coinsurance requirements.

Annual Maximums

Out-of-pocket Maximums for In-network Services
Your annual out-of-pocket maximum per calendar year for covered in-network services is:

- $600 for one member
- $1,200 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family out-of-pocket maximum.
  - If the one member out-of-pocket maximum has been met, but not the family out-of-pocket maximum, we will not require any more cost-sharing amounts for that member the remainder of the calendar year.
  - Cost-sharing for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.

Your **deductible, copayment and coinsurance** requirements for covered services performed by in-network providers are combined to meet the annual in-network out-of-pocket maximum.

Out-of-pocket Maximums for Out-of-network Services
Your annual out-of-pocket maximum per calendar year for covered out-of-network services is:

- $1,250 for one member
- $2,500 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family out-of-pocket maximum.
  - If the one member out-of-pocket maximum has been met, but not the family out-of-pocket maximum, we will not require any more cost-sharing amounts for that member the remainder of the calendar year.
  - Cost-sharing for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.

Your **deductible, copayment and coinsurance** requirements for covered services performed by out-of-network providers are combined to meet the annual out-of-network out-of-pocket maximum.

Annual Maximums (continued)

Your cost-sharing requirements under your BCBSM prescription drug certificate also contribute to the annual in-network and out-of-network maximums stated above.

Specific prescription drug expenses that will not apply toward your annual out-of-pocket maximum include the following:

- Payment for noncovered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- The 25 percent member liability for covered drugs obtained from a nonparticipating pharmacy.

Cost-sharing amounts applied toward the annual out-of-pocket maximum for out-of-network services also count toward the out-of-pocket maximum for in-network services. However, amounts applied toward the in-network out-of-pocket maximum do not count toward the out-of-network out-of-pocket maximum.

Once these amounts are satisfied, all covered benefits under this certificate and any applicable BCBSM prescription drug program certificate will be covered at 100% of the approved amount for the remainder of the calendar year.

Maximums for Days of Care or Visits
If annual maximums (days or visits) or lifetime maximums (days or visits) apply for specific services, they are described elsewhere in your certificate.